

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2012
NAME OF PROVIDER OR SUPPLIER ADAMS MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 MERCER AVE DECATUR, IN 46733		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility #: 004747</p> <p>Type of survey: State Licensure off-site HFAP Accreditation Survey</p> <p>Date of HFAP Survey: Sept 12, 2012 Date of off-site review: 11/5/2013</p> <p>Based on review of the 09/12/2012 HFAP survey, it has been determined that Adams Memorial Hospital meets the requirements for State Licensure in Indiana.</p> <p>Nancy Otten, RN</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE